Case No: B3/2015/1705

Neutral Citation Number: [2017] EWCA Civ 63
IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT
QUEEN'S BENCH DIVISION
Mr Justice Kenneth Parker
[2015] EWHC 1289 (QB)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 10/02/2017

Before :

LADY JUSTICE BLACK
LORD JUSTICE IRWIN
and
LORD JUSTICE HENDERSON

- -

Between :

EXP	**Respondent (Claimant)**
- and -	
DR CHARLES SIMON BARKER	**Appellant (Defendant)**

- -
- -

Grahame Aldous QC and Stuart McKechnie (instructed by **Russell-Cooke LLP**) for the **Respondent (Claimant)**
Angus McCullough QC (instructed by **Clyde & Co LLP**) for the **Appellant (Defendant)**

Hearing date: 31 January 2017

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Judgment

Lord Justice Irwin:

Introduction

1. This is an appeal by the Defendant Dr Charles Barker from the judgment of Kenneth Parker J of 7 May 2015. The Appellant is a consultant neuroradiologist. The judge found that the Appellant negligently failed to identify and report a right middle cerebral artery aneurysm in the course of his review of an MRI brain scan carried out on the Respondent on 6 April 1999. The Appellant submits that the judge fell into error. It is said he failed to identify and to apply the "Bolam" test (*Bolam v Friern Hospital* [1957] 2 AER 118); further, that having admitted the evidence of the Appellant's expert Dr Molyneux, the judge failed to evaluate that evidence on its merits; it is submitted that the judge wrongly performed a "balancing act" between competing expert opinions and finally, that the judge erred in holding that Dr Molyneux had an interest or bias in the outcome of the case which was "sufficient of itself to dismiss his expert opinion" when set against that of the Respondent's expert, Dr Butler.

The Facts

2. The Respondent was born in 1965. In March 1999, whilst working as a barrister in court, the Respondent experienced an episode of visual disturbance. She was admitted to the Accident and Emergency Department at the Queen Alexandra Hospital in Portsmouth. Following attendance on her general practitioner she was referred privately to a consultant orthopaedic surgeon, Mr Harley. He made a provisional diagnosis of spinal spondylosis and he organised a magnetic resonance imaging (MRI) scan on the spine. The Respondent underwent an MRI scan of the lumbar spine and of the brain. Fortuitously, the Respondent retained the packaging for these scans, which indicated that the MRI of the brain was reviewed by the Appellant. The Appellant was then a consultant neuroradiologist, working in Southampton.

3. In April 1999, the Respondent saw Mr Harley once more to discuss the results of the scans. The Respondent was told that she had a specific gene for ankylosing spondylitis and that the scan of the lumbar spine had revealed degenerative changes. She was referred to a consultant rheumatologist. At the same time, Mr Harley told the Respondent that her brain scan was entirely normal and that conclusion was repeated in Mr Harley's letter to her GP of 12 April 1999.

4. It is the Respondent's case that the brain scan was not normal, but indicated the presence of an aneurysm on her right middle cerebral artery ["MCA"] which should have been identified by the Appellant, who had specific expertise in the reporting of brain scans. It is accepted that Mr Harley, the Respondent's GP and she herself all relied on his report.

5. Shortly before the trial, the Appellant conceded causation. Had the view been taken that the scan appearance was abnormal in April 1999, the Respondent would have been referred for a neuro-surgical/neuro-vascular opinion. If she had been referred, any aneurysm would have been identified. The Respondent was then 34 years of age, and active treatment would have been offered. Either of the potential procedures would have had a very high likelihood of curing the aneurysm, with an unremarkable

postoperative course and outcome, and an excellent long term prognosis. Even if the Respondent had not undergone immediate surgery, she would have been subject to frequent repeat MRI imaging and continuing surveillance. It is likely that on-going surveillance would have identified progression in the aneurysm, leading to definitive surgery before September 2011.

6. By 2011, the Respondent had become a district judge. On 8 September 2011, she collapsed in her home and lost consciousness. She was taken by ambulance to the Accident and Emergency Department at the Queen Alexandra Hospital in Portsmouth. A CT brain scan revealed an acute parenchymal haemorrhage, 5cm x 4.5cm in extent, centred on the Respondent's right temporal lobe. The bleed had produced a 2.5cm shift in the brain from the mid-line. The bleed had been caused by a ruptured aneurysm. A CT scan revealed a partially thrombosed aneurysm originating from the right MCA. Emergency surgery was performed, clot removed and a partly calcified bi-lobed aneurysm was observed. The consultant neurosurgeon, Mr Duffill, clipped the aneurysm and evacuated the haematoma. The Respondent was discharged home on 30 September.

7. The Respondent has suffered significant damage from this episode. She has a left field visual field loss causing 50% blindness, left-sided hemiparesis, a degree of paralysis and weakness in the left leg, chronic pain and spasticity, weakness and imbalance, cognitive impairments, impaired speech, hearing, swallow, smell and taste; fatigue, headaches, periodic bowel and bladder incontinence; disinhibited behaviour, depression and panic attacks.

8. On 14 December 2011, the Respondent saw Mr Duffill at an outpatient follow-up appointment. She took with her the 1999 MRI images. Mr Duffill concluded that he could identify on one of them the aneurysm which had subsequently ruptured. He wrote to the Respondent's GP on 28 December:

> "I think in retrospect one can see that the middle cerebral artery bifurcation on the right is abnormal and that this represents a small aneurysm which was present twelve years ago."

The Issue at Trial

9. As the judge put it, the issue at trial was "relatively narrow", namely "whether the MRI scan in 1999 did indicate the presence of an aneurysm which a reasonably competent neuroradiologist would have identified and reported". As I have said, there is a dispute as to whether the judge correctly formulated the *Bolam* test, and I address that below. At least conceptually, there were two issues: whether there was an aneurysm in 1999, even if smaller in dimension, and secondly, whether a competent neuroradiologist should have identified a possible abnormality on the scan warranting further investigation. However, the two issues are very closely connected, since the principal evidence bearing on each consists of the scan images, and the opinions of experts about those images.

The Expert Evidence at Trial

10. The Respondent relied on two experts, the first being Dr Paul Butler MRCP FRCR, a consultant neuroradiologist at the Barts and London NHS Trust. Dr Butler has been a

consultant since 1986 with a range of NHS and private appointments. He has been an examiner for the FRCR examinations and has lectured in neurology. He has made, as the judge found, many presentations in his specialist area and is an author in a number of publications. The Respondent also relied on an expert report of Mr Peter Kirkpatrick, a consultant neurosurgeon at the University of Cambridge Hospital Trust since 1995.

11. The Appellant relied on the opinion and evidence of Dr Andrew Molyneux, an honorary consultant neuroradiologist at the University of North Staffordshire NHS Trust. As the judge acknowledged, there is no doubt as to Dr Molyneux's distinguished clinical career. He was a consultant neuroradiologist at the Radcliffe Infirmary, Oxford from 1999 to 2004. He has been an examiner for the MSc degree in radiology and an honorary senior clinical lecturer at Oxford University. He has had a particular interest in the treatment of cerebral aneurysms and of brain arteriovenous malformations. As the judge put it:

> "[Dr Molyneux's] *curriculum vitae* provided an impressive list of articles in peer reviewed journals since 1998, a large number of which covered his special area of aneurysms."

12. Before the trial, the Appellant served a written report and two supplementary reports from Mr Paul Byrne FRCS, consultant neurosurgeon at the Nottingham University Hospital NHS Trust. In the event, Mr Byrne was not called to give evidence and the Appellant did not seek at trial to rely upon his reports. Nevertheless, as we shall see, the report from Mr Byrne became significant.

13. The Appellant's expert, Dr Molyneux, indicated that the MRI appearance indicated tortuosity ("that is to say a twisted shape or form") of that artery. Dr Molyneux marked that on copies of images 14 and 33 of study 2 from the 1999 MRI scan appended to his report. I should make clear that the Appellant's case is that this description did not imply any abnormality. In his August 2014 report, the Respondent's witness Dr Butler focussed on image 33. This image includes the right sylvian fissure, and the middle cerebral artery. Dr Butler drew an arrowhead on that image, pointing to what he considered was "an aneurysm on that artery not tortuosity of that artery".

14. It was agreed between the parties, and indeed agreed by the Appellant in his own witness statement, that when a neuroradiologist reviews imaging, he or she is "first and foremost influenced by the clinical details on a request form". Here, the request did not relate to the MCA. However, there follows, as Dr Barker again agrees, a general survey. It was agreed that a reasonably skilled neuroradiologist should include a perusal of the basal cerebral arteries in such a survey.

15. In his report of 6 August 2014, Dr Molyneux stated in relation to this scan:

> "In my opinion there is no abnormality seen in the brain. I am not able to identify any clear evidence of a cerebral aneurysm on this scan. The right sylvian fissure is prominent with a prominent CSF space. The proximal middle cerebral arteries … are quite prominent on both sides and all the vessel flow voids seen in the circle of Willis are quite prominent. I am not

able to definitely identify an aneurysm on this scan. The findings on this MRI scan are within the range of normal in an adult patient and I would have reported this scan as such."

16. Later in the report Dr Molyneux amplified his views, stating:

> "There is no visible abnormality on the 1999 MRI scan at the right MCA bifurcation. The aneurysm that 12 years later ruptured … was pointing laterally from the posterior aspect of the trifurcation of the right MCA….
>
> Incidental intracranial aneurysms occur in the adult population with a frequency of about 3%. The time course of formation and rupture of intracranial aneurysms is unknown. The most widely held opinion amongst experts in this field is that the majority of small aneurysms that present with rupture causing a SAH do so relatively soon after their formation. This is the only realistic explanation for the discrepancy in the observed natural history of small unruptured cerebral aneurysms found incidentally which, based on the best literature evidence, have a very low likelihood of rupture ..."

17. Dr Butler's conclusions were as follows:

> "Even taking a sceptical view there is, at the very least, a high index of suspicion of an aneurysm on the 1999 scan, notably study 2, image 33 on that study. I would have expected that a responsible neuroradiologist would have raised this possibility in the report and requested further imaging, notably a magnetic resonance angiogram.
>
> The site of the subsequent haemorrhage was centred (*sic*) this region and, on the balance of probabilities, the aneurysm identified in 1999 was responsible for it.
>
> DISCUSSION OF THE 2011 CT ANGIOGRAM
>
> Because the suspected aneurysm was not characterised fully in 1999 it is not possible to make a direct comparison between the 'routine' cranial MR scan at that time and the September 2011 CTA.
>
> Equally it is not possible to comment on the precise shape of the aneurysm on the 1999 MR scan.
>
> By far the more likely scenario is that the aneurysm, which I firmly believe to have been present in 1999, ruptured in 2011 and correspondingly it is extremely unlikely that an aneurysm arising 'de novo' in exactly the same location was responsible for the haemorrhage."

18. In October 2014, responding to a question given to him on behalf of the Appellant, Dr Butler commented further as follows:

> "Rapidly flowing bloods in arteries (and blood flowing in patent arterial aneurysm) is displayed as a 'signal void' on MRI and is black on T2 and T2 FLAIR sequences.
>
> The middle cerebral arteries travel in the sylvian fissure on each side. In EXP's case the signal void in the right sylvian fissure is too prominent to be explained on the basis of the normal middle cerebral artery and its branches alone. There is no evidence of undue arterial tortuosity or arterial ectasia on the subsequent CT angiogram and the two sides on the MR scan are different, the left being normal.
>
> A CT angiogram is a special investigation utilising thin axial sections of 1mm to display arterial anatomy in some detail, incorporating 3D.
>
> The MR examination of 1999 was a routine scan with a slice thickness of the order of 5mm. Accordingly the abnormal signal void in the right sylvian fissure is a composite mainly of the aneurysm sac and immediately adjacent arteries."

19. The two neuroradiologist experts held a joint expert meeting by telephone on 17 November 2014. They failed to agree on the critical point on the 1999 scan. Their disagreement was recorded in the following terms:

> "2) Please look at the cranial MRI scan dated 6th April 1999, and in particular image 33 study 2 thereof. Do you consider that there is:
>
> i) A right middle cerebral artery aneurysm on this scan?
>
> ***AM says: there is no evidence of a right middle cerebral artery (MCA) aneurysm on this scan.***
>
> ***PB says: there is an aneurysm present on this scan.***
>
> Any abnormality on this scan that you consider would warrant further investigation?
>
> ***AM says: no he does not think further investigation is warranted.***
>
> ***PB says: an MR angiogram is warranted.***"

20. The Respondent's expert neurosurgeon, Mr Kirkpatrick, also gave his opinion on the 1999 scan. The key passage in his report, cited by the judge in paragraph 42 of the judgment, reads:

> "42. The key issue here relates to whether or not the images of 06.04.99 were abnormal. I have reviewed these myself, and

> from a neurosurgical perspective who sees hundreds of MRI scans on an annual basis, the images are clearly abnormal and, unequivocally in my view, demonstrate the presence of a sizeable right middle cerebral artery aneurysm measuring between 5-6mm in its maximum dimension. This is not a small aneurysm, and the suggestion that the images show no vascular abnormality, or at best a small aneurysm, in my view is wrong. It would of course be for the expert neuroradiological and general radiological commentary to identify standards of reporting in this matter, but from a neurosurgical and neurovascular perspective I have no doubt in my mind what the MRI scans show. Indeed, I note the commentary from Dr Paul Butler in his expert report that he also considers that the aneurysm was visible on the cranial MRI scan performed in April 1999. He considers that the site of the subsequent haemorrhage was centred in this region and on balance of probabilities the aneurysm identified in 1999 was responsible. From the neurovascular point of view I would totally agree with his views."

21. As I have indicated, the Appellant served three reports from Mr Paul Byrne, consultant neurosurgeon, but did not in the event call him to give evidence. In Mr Byrne's main report of August 2014, he explained that in 1999 he was part of a neurovascular team involved in the management of "incidentally found unruptured cerebral aneurysms". He stated that:

> "In 1999 I would have referred to the enclosed article (New England Journal of Medicine Volume 339 No.24 10 December 1998 pages 1725-1733 "*Unruptured Intracranial Aneurysms – Risk of Rupture and Risks of Surgical Intervention. The international study of unruptured intracranial aneurysms investigators" (ISUIA)* That paper, which was widely held as the definitive scientific evidence on the risk of rupture of unruptured aneurysms, looked at a group of patients from 53 participating centres in the United States, Canada and Europe. …. The paper notes *"The management of unruptured aneurysms depends on the natural history of these lesions and on morbidity and mortality rates associated with repair. On the basis of the rupture rates and treatment risks in our study, it appears unlikely that surgery will reduce the rates of disability and death in patients with unruptured intracranial aneurysms smaller than 10mm in diameter and no history of subarachnoid haemorrhage.*"

22. It will be evident that that expression of views by Mr Byrne, based on the ISUIA study he quoted, bore on causation, which remained in issue until very shortly before the trial. The conclusion which might be drawn from the paper quoted was that in 1999, even had the aneurysm been present and identified as present, Mr Byrne would not necessarily have recommended any surgical intervention.

The Connection Between the Appellant and Dr Molyneux

23. As the judge set out between paragraphs 45 and 57 of his judgment, there was in fact a close connection between the Appellant and his principal expert witness. That was not declared by the Appellant or by Dr Molyneux. Indeed, the judge clearly concluded that some steps had been taken which might have had the effect of avoiding the emergence of the connection. This aspect of the case caused him real concern, led him seriously to consider excluding Dr Molyneux's evidence from the trial, and affected significantly the weight which the judge was prepared to attach to his evidence.

24. The Appellant attached a *curriculum vitae* to his witness statement. This showed that he had become a registrar in radiology at "Oxford RHS" in August 1984, remaining as a registrar until March 1989 when he became a senior registrar in neuroradiology at the Radcliffe Infirmary, Oxford. Part of his training in neuroradiology prior to his appointment as a senior registrar, had been spent over two and a half years in the department of neuroradiology at the Radcliffe Infirmary. In the relevant parts of his *curriculum vitae*, Dr Barker did not mention Dr Molyneux at all. By contrast, dealing with a shorter period of training spent in the department of neuroradiology at the Sahlgren Hospital, Gothenburg, the judge noted that Dr Barker had taken care "in this instance, to note in his CV that this enabled him to gain further practical experience under the supervision of Dr P Svendsen".

25. Nor did Dr Molyneux indicate in any way a connection with Dr Barker. His CV did state that he had held appointments in the Radcliffe Infirmary during the late 1980s and early 1990s.

26. As the judge stated:

> "48. Someone comparing these respective CVs would reasonably infer that Dr Barker would have had contact, possibly significant contact, with Dr Molyneux from about August 1984, … until October 1991 … However, someone looking at the respective CVs would not know the exact nature and extent of any connection between Dr Barker and Dr Molyneux."

27. The judge summarised the connection between them, and how the matter emerged, as follows:

> "52. It emerged only in cross-examination at the trial that the connection between Dr Barker and Dr Molyneux had been lengthy and extensive. Dr Molyneux had trained Dr Barker during his seven years of specialist radiology training, and in particular had trained him for two and a half years as a registrar and senior registrar in neuroradiology, including the particular area of interventional radiology in which Dr Molyneux specialised and in which Dr Barker had a special interest. It is clear that they had worked together closely over a substantial period. They had written together a paper for the 14th International Symposium on radiology, a paper not shown on

> Dr Molyneux's list of publications [emphasis added], and Dr Molyneux told the Court that they might have co-operated on other papers which he could no longer specifically recall. Dr Molyneux helped Dr Barker to obtain foreign placements … Dr Barker accepted that Dr Molyneux had guided and inspired his practice, and Dr Molyneux had helped Dr Barker become a consultant in Southampton. They had also been officers together on the committee of the British Society of Radiologists, Dr Barker having been Treasurer at the time when Dr Molyneux, being a committee member, was nominated President.
>
> 53. It also emerged that Dr Barker had suggested that Dr Molyneux should be a defence expert. He had first been asked in cross examination whether he had chosen Dr Molyneux as an expert, which he denied, and he had had to be prodded with a further question to elicit the full picture."

The judge also expressed himself as being "taken aback" by the fact that "in an unguarded moment" Dr Molyneux referred to the Appellant as "Simon", which although not his first name, is the familiar name by which he is known.

28. The judge took the view that the failure to disclose this close connection was "a very substantial failure indeed", the more so because there had been a specific direction in the case that:

> "Experts will, at the time of producing their reports, incorporate details of any employment or activity which raises a possible conflict of interest."

29. Since all of this only emerged in the course of the trial, it was too late for any alternative expert to be engaged. At the close of the case, counsel for the Respondent, Mr Grahame Aldous QC, submitted to the judge that he should entirely exclude Dr Molyneux's evidence. Following argument and careful consideration, the judge declined to do so. An important part of his reasoning was that if he did so, the Appellant's case must immediately fail.

30. However, in the course of explaining his reasoning when rejecting that application, the judge raised a specific concern about Dr Molyneux's approach to the ISUIA paper to which I have referred above, which had been relied on by Mr Byrne in his expert report. The judge described this matter as something which "again raised doubts in my mind about Dr Molyneux's independence in this case" (paragraph 59). Putting the matter shortly, the ISUIA paper in the New England Journal of Medicine was the subject of very heavy criticism over a period of years, with suggestions of poor methodology and systemic bias in the selection of patients. In January 2002, the Journal of Neurosurgery-

> "published a number of articles and editorials about the study, and the conclusions drawn contradict those of the report, with the editorial echoing the original criticisms in 1999. The editor … went as far as saying that the credibility of those involved in

> the challenged study had been "severely compromised"." (paragraph 60)

31. The judge observed that in those circumstances it was "wholly unclear why Mr Byrne had referred to the study in the terms that he did" (paragraph 61). But the matter also affected Dr Molyneux. The judge went on as follows:

> "61. … The significance of this in the present context is that Dr Molyneux had been an executive committee member of the ISUIA and could have been expected to know of the criticisms of the study and to realise that Mr Byrne's evidence was seriously deficient and misleading. Dr Molyneux accepted in cross examination that he had seen a copy of Mr Byrne's proposed report that contained the relevant passage and he also agreed that the study could not accurately be described in the terms used by Mr Byrne, given the criticisms and controversy already mentioned.
>
> 62. He knew that Mr Byrne's report was being relied upon in respect of what, until very shortly before the trial, was an important contested issue, yet Dr Molyneux did nothing at that stage to draw the attention of Mr Byrne, or anyone else, to what he knew to be the case. The justification for this appeared to be that Mr Byrne was the expert on neurosurgery, and it was not within Dr Molyneux's remit to comment on any aspect of the neurosurgical evidence.
>
> 63. I find that explanation difficult to accept."

32. The judge accepted that Dr Molyneux was an eminent neuroradiologist. There was no doubt about his clinical expertise and competence to assist the Court. The point was, bluntly, whether he was partial. The judge indicated that he had come very close to ruling that Dr Molyneux's evidence was not admissible, although he declined to do so in the end. However he went on to say:

> "65. …I must bear powerfully in mind, when I assess the weight that I should give to the evidence, the reservations that I retain about Dr Molyneux's independence and objectivity in this case."

The Judge's Conclusions

33. Given the way the criticisms of the judge are formulated by the Appellant, it is appropriate to begin by considering the Defendant's closing submissions. The written submissions began as follows:

> "As identified in D's opening, there are only two remaining issues in the case which fall to be determined:
>
> (1) Whether there was in fact an aneurysm present in 1999 as revealed by the imaging …

> (2) Thus if, contrary to the Defendant's case, it is likely that an aneurysm was present in 1999, there is an issue as to **whether no reasonably competent consultant neuroradiologist would have failed to have identified or suspected the presence of aneurysm from the imaging obtained in 1999**…. Does the opinion of Dr Molyneux represent that of a respectable and responsible body of medical opinion? If it does, then the claim fails the *Bolam* test."

34. Given the way the matter was then put, it is wholly unsurprising that the judge expressed the matters he had to decide as I have summarised in paragraph 9 above. It is also beyond doubt that the Defendant's case on both the issues identified (or both parts of the issue as expressed by the judge) depended on the evidence of Dr Molyneux. His was the only evidence that the 1999 scan appearance was normal, and his was the only evidence suggesting that it was within the range of acceptable practice for a competent neuroradiologist to consider that the scan image did not mandate further investigation.

35. I have already touched on some of the key aspects of the evidence upon which the judge relied in concluding that there was in fact an aneurysm in 1999. He relied on the views of Dr Butler. He relied on the view of Mr Kirkpatrick. There can be no difficulty in the latter: a consultant neurosurgeon may defer to a consultant neuroradiologist on imaging, but neurosurgical evidence is of real worth. As the judge observed:

> "Mr Kirkpatrick … as a neurosurgeon, ... has substantial experience in reviewing and interpreting MRI scans for the purpose of, among other things, considering whether there is evidence of the possible presence of an aneurysm."

In paragraphs 68 to 70 of the judgment, the judge drew real support from this evidence.

36. In addition, the judge had the report of the operating surgeon, Mr Duffill. He was careful not to place too much weight on this opinion, given that Mr Duffill did not give evidence, was not cross examined and there might have been "an understandable confirmation bias" (paragraph 67). However, in my view, the judge might properly have viewed this material as not insignificant, if subsidiary, support for the Claimant's case.

37. Finally, there is the stark fact, as Dr Butler stated and the judge found:

> "75. … the actual aneurysm that ruptured in 2011 was in the same location as the putative aneurysm visible from the images of 1999 MRI scan. Mr Kirkpatrick held the same opinion. Dr Molyneux considered that the putative "abnormality" in the 1999 images of the MRI scan was not in the same location as the actual aneurysm that ruptured in 2011. A central difficulty on this question was that the 1999 MRI scan was a relatively crude instrument for ascertaining the precise location and exact

features of an aneurysm, if an aneurysm were indeed present. Dr Butler stressed the difficulty in seeking to interpret the precise characteristics of the putative aneurysm.

76. Dr Butler did accept, within the significant limitations of the 1999 MRI scan that the orientation of the feature which he identified as an aneurysm in 1999 appeared to be anterior. It was agreed that the actual aneurysm on the detailed imaging in 2011 emanated from the posterior wall, laterally directed. That apparent discrepancy has to be set against the improbability that the aneurysm that ruptured in 2011, albeit on any view in at least very close proximity to the abnormality that appeared in the 1999 images, was a different and more recent aneurysm. Furthermore, Mr Kirkpatrick in his oral evidence stated that the vessel may have rotated as a result of the haematoma. It is correct that Dr Butler had not mentioned such a possibility but I do nonetheless attach weight in this context to Mr Kirkpatrick's explanation, given as it was on a matter within his acknowledged medical expertise.

77. Having considered the evidence on this question, I conclude, following the evidence of Dr Butler and Mr Kirkpatrick, that on a balance of probability the aneurysm that ruptured in 2011 was an aneurysm that was present in 1999…."

38. The central conclusions of the judge on the negligence issue were as follows:

"71. … Ultimately, it appears that Dr Butler was relying upon his considerable experience in concluding that there was sufficient evidence of an aneurysm on the 1999 imaging to require further investigation. That has to be set against the opinion of Dr Molyneux, that it was reasonable for a competent radiologist to interpret the 1999 imaging as showing no relevant abnormality. I have to decide, of course, whether a competent neuroradiologist in the position of the Defendant could reasonably have concluded that there was not sufficient evidence of "abnormality" to require further investigation for the presence of a possible aneurysm.

72. I have not found it easy to resolve this conflict between two leading experts. I do see force in Dr Molyneux's opinion that the features of the 1999 imaging were consistent with the normal anatomy of the brain in that region, and did not evidence abnormality that required further investigation. However, it does appear to me that that opinion in this particular case rests ultimately upon a judgement informed by accumulated experience and expertise in the relevant area. Dr Butler, based on his experience and expertise, believed that the putative abnormality could not be safely and adequately explained by normal anatomy of the brain and that it required further investigation. That was his judgement. It did not seem

> to me that Dr Molyneux thought that that was an unreasonable judgement, although he did not agree with it.
>
> 73. Where the core issue in a case turns, as it does here, on the court's ability to evaluate the competing and finely balanced medical judgements of rival experts, the court's confidence in the independence and impartiality of the respective experts must play an important role. I have to say, with considerable regret, that by reason of the matters set out earlier in this judgment my confidence in Dr Molyneux's independence and objectivity has been very substantially undermined. On the other hand I have complete confidence in the independence and objectivity of Dr Butler, and I much prefer to accept his judgement, formed on the basis of his great experience and skill, that (i) a competent neuroradiologist would have been considerably troubled by the relevant images from the 1999 MRI scan; and (ii) would not have concluded that those images could be prudently and adequately explained by "normal brain anatomy", contrary to Dr Molyneux's view; and (iii) would have concluded that the images did show the presence of an aneurysm.
>
> 74. I am fortified in accepting Dr Butler's evidence by the fact that it was supported by Mr Kirkpatrick, and, for the reasons given, I am entitled to give weight to the evidence of Mr Kirkpatrick as an experienced neurosurgeon..."

39. Mr McCullough QC makes the criticism that the judge expressed his conclusion on the issue of negligence in paragraphs 71 to 74 of the judgment, before he set down his conclusion on the logically prior issue of whether there was an abnormality present in 1999. He submits correctly that all the available evidence may properly be brought to bear on the question whether an abnormality existed in 1999, whereas the negligence issue must be decided on the 1999 scan and on the relevant expert opinion. For myself, I can agree that the judgment might have read more happily, particularly for those not involved in the case, had the judge set down his conclusions the other way round. However, I see no basis for saying there was any improper reliance on aftercoming evidence on the negligence issue. There was no confusion or difficulty of substance. Subject to his arguments as to the judge's application of the *Bolam* test, Mr McCullough does not suggest there was.

The Grounds of Appeal

40. The following Grounds of Appeal are advanced:

    i) The learned judge failed correctly to identify and formulate the applicable *Bolam* test in evaluating the actions of the Defendant.

    ii) The judge failed to apply the *Bolam* test to the expert evidence relating to the Defendant's response to the 1999 imaging.

iii) Having admitted the evidence of the Defendant's expert, Dr Molyneux, the judge failed to evaluate it on its merits.

iv) The judge wrongly performed a "balancing" between the rival opinions of the neuroradiology experts.

v) The judge erred in holding that Dr Molyneux had an interest in the outcome of the case that was sufficient of itself to dismiss his expert opinion when set against that of Dr Butler.

41. Mr McCullough grouped his Grounds, Ground 1 with Ground 2, and Grounds 3 to 5 together.

42. The submission on Ground 1 is straightforward: in his judgment the judge is said to have misstated the *Bolam* test. Mr McCullough conceded that the judge stated the test correctly in paragraph 71, quoted above. He conceded that if that were the only reference to the test, there would have been no appeal, at least on this point. However, Mr McCullough relies on two further references: paragraph 25 "an aneurysm which a reasonably competent neuroradiologist would have identified and reported", and paragraph 78 where the judge wrote "I find that a competent practitioner would have concluded that the images in the 1999 MRI scan showed the presence of an aneurysm".

43. I roundly reject these Grounds. It is clear that the judge was focussed on the obligation of a competent practitioner. As a matter of common usage, the indefinite article stood for "any" in paragraphs 71 and 78. There was no confusion or misdirection. I see no basis for the suggestion the judge failed to apply the *Bolam* test.

44. In addressing Grounds 3 to 5, Mr McCullough began by taking us to authority. In *Maynard v West Midlands RHA* [1984] 1 WLR 634, the House of Lords were concerned with a case where, under pressure of time, a physician and a surgeon moved to operate early on the claimant, before the outcome of tests which would have shown that she was suffering from tuberculosis, rather than Hodgkin's disease. The doctors all along thought tuberculosis more likely, and were aware of the risks of surgery, which in fact eventuated. However, they took the decision to proceed to surgery, because Hodgkin's disease was fatal unless remedial steps were taken in the early stages of the disease. The trial judge expressed himself as preferring the view of the claimant's experts that a responsible body of the relevant medical professionals would say the decision was unreasonable. The House of Lords held that it is not sufficient for a judge to conclude that one body of opinion is preferable to another, if both are within the range of reasonable professional views. It is necessary, before the threshold is passed, to show that no responsible body of relevant professional opinion would say the practice was reasonable. See: *Maynard*, judgment of Lord Scarman, at page 638E to H.

45. Mr McCullough also took the Court to another very well known authority, *Bolitho v City and Hackney HA* [1998] AC 232. Here the case concerned a child who collapsed in respiratory failure. The general practitioner who had been alerted to the child's condition, failed to attend. The child suffered a cardiac arrest and severe brain damage, before eventual resuscitation. The Court had to consider the proper approach

to causation, considering the outcome if the general practitioner had attended before the cardiac arrest and collapse.

46. The leading judgment was given by Lord Browne-Wilkinson, with whom the others agreed. The House accepted the claimant's argument that the case could succeed, even if it was improbable that the relevant intervention (intubation) would have followed, had the doctor concerned attended. The House accepted that causation would be established if it was shown that the intervention would have been required, in the sense that no responsible body of opinion would have supported the omission of intubation. In other words, a defence to causation could not be established by reference to a probable response by the defendant doctor which would in itself be negligent.

47. It was in this rather particular context, that the House of Lords moved on to consider a further step: what if the opinion upheld by a body of experts is unreasonable? Lord Browne-Wilkinson answered that question as follows:

> "My Lords, I agree with these submissions to the extent that, in my view, the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from a number of medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice. In the *Bolam* case itself, McNair J. stated [1957] 1 WLR 583, 587, that the defendant had to have acted in accordance with the practice accepted as proper by a "*responsible* body of medical men." Later, at p. 588, he referred to "a standard of practice recognised as proper by a competent *reasonable* body of opinion." Again, in the passage which I have cited from *Maynard's* case, Lord Scarman refers to a "respectable" body of professional opinion. The use of these adjectives - responsible, reasonable and respectable - all show that the court has to be satisfied that the exponents of the body of opinion relied upon can demonstrate that such opinion has a logical basis. In particular in cases involving, as they so often do, the weighing of risks against benefits, the judge before accepting a body of opinion as being responsible, reasonable or respectable, will need to be satisfied that, in forming their views, the experts have directed their minds to the question of comparative risks and benefits and have reached a defensible conclusion on the matter. (p241G/242B)
>
> ……
>
> These decisions demonstrate that in cases of diagnosis and treatment there are cases where, despite a body of professional opinion sanctioning the defendant's conduct, the defendant can properly be held liable for negligence (I am not here considering questions of disclosure of risk). In my judgment that is because, in some cases, it cannot be demonstrated to the judge's satisfaction that the body of opinion relied upon is

> reasonable or responsible. In the vast majority of cases the fact that distinguished experts in the field are of a particular opinion will demonstrate the reasonableness of that opinion. In particular, where there are questions of assessment of the relative risks and benefits of adopting a particular medical practice, a reasonable view necessarily presupposes that the relative risks and benefits have been weighed by the experts in forming their opinions. But if, in a rare case, it can be demonstrated that the professional opinion is not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.
>
> I emphasise that in my view it will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence. As the quotation from Lord Scarman makes clear, it would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the bench mark by reference to which the defendant's conduct falls to be assessed. (p243A-D)"

48. Against that backdrop, Mr McCullough makes the following submissions. The judge explicitly recognised Dr Molyneux's experience and expertise. His concern at the witness's lack of independence did not cause him to exclude the evidence. If the evidence was to be admitted then, because of Dr Molyneux's admitted expertise, his evidence must necessarily be accepted as establishing that a responsible body of neuroradiologists would not have referred the patient for further investigation. That is all the more so because the judge observed that he saw the "force" of Dr Molyneux's opinions, and had not "found it easy to resolve the conflict" between the experts. In those circumstances, says Mr McCullough, the judge cannot resolve the matter unless, on close analysis, he finds the views of Dr Molyneux to be unreasonable.

49. In reply to these submissions, Mr Aldous QC for the Respondent argued that the judge was fully entitled to place much less weight on the evidence of Dr Molyneux: he had found him to lack the necessary independence. As is clear from *Toth v Jarman* [2006] EWCA Civ 1028, and from the current (18th) edition of *Phipson on Evidence* at 33-26/30, a lack of independence and impartiality in an expert can properly go to admissibility, or to weight. That proposition is consistent with the recent Scottish case of *Kennedy v Cordia (Services) LLP* [2016] UKSC 6; [2016] 1 WLR 597. Indeed, says Mr Aldous, there is a great body of authority to show that partiality in a witness can and indeed should diminish the weight of evidence. Here, the judge was simply unable to rely on Dr Molyneux's evidence as to acceptable practice.

Conclusions

50. I have already made clear that I consider the judge had well in mind the *Bolam* test, properly formulated.

51. In considering Grounds 3 to 5, the starting point is to identify what the judge decided. He considered that the witness had so compromised his approach that the decision to admit his evidence was finely balanced, and that the weight to be accorded to his views must be considerably diminished. In my view he was fully entitled to take that view. Indeed, had he decided to exclude Dr Molyneux's evidence entirely, it would in my view have been a proper decision. Our adversarial system depends heavily on the independence of expert witnesses, on the primacy of their duty to the Court over any other loyalty or obligation, and on the rigour with which experts make known any associations or loyalties which might give rise to a conflict. Dr Molyneux failed to do so here, despite an express direction to that effect. Indeed, the omission of mention of papers co-authored with Dr Barker points in the other direction.

52. Moreover, there was good reason for doubting his approach to the problem in hand. He knew that his neurosurgical colleague was relying on research which was highly criticised. Dr Molyneux was a committee member of the ISUIA. As the judge observed, Dr Molyneux knew the study had been inaccurately described by Mr Byrne, and knew that evidence might well be given which, as the judge described it, "was seriously deficient and misleading". Moreover, it was in my judgment an inadequate explanation from Dr Molyneux to say this arose from the neurosurgical evidence, and was no business of his. Because of the controversial nature of the paper, and Dr Molyneux's position in the organisation associated with the research, it was entirely possible that he might himself have been cross examined about it.

53. In circumstances such as those arising here, the scrupulous expert in Dr Molyneux's position should be pointing out the problem to the legal team well ahead of trial. No doubt that will usually be done in privileged communication. In many instances, a Court will be cautious in drawing inferences for that reason. However, on the facts of this case, the judge found that Dr Molyneux "did nothing": see paragraphs 62 and 63. Mr McCullough made no submissions to us in respect of that conclusion.

54. Dr Molyneux's case was that there was no aneurysm in 1999. Yet he appears to have given no explanation as to what is otherwise an impressive coincidence. Even allowing for some disagreement as to the precise angle or direction of the supposed tortuosity on the 1999 scan and the precise position of the aneurysm, given that it was common ground the 1999 imaging was not of the resolution or quality to be found in the later imaging, and that on any view, the aneurysm was larger than any defect in 1999 (thus affecting more of the wall of the artery), it was striking that Dr Molyneux had no convincing explanation addressing this coincidence. This point clearly was of significance for the judge. He was fully entitled to accept the analysis of Dr Butler, as he did in paragraphs 75 to 77 of his judgment.

55. Moreover, it is clear that the judge simply did not feel able to rely on Dr Molyneux's evidence as establishing that a responsible body of neuroradiologists would have failed to refer the Respondent. In my view he had no obligation to do so. The Respondent succeeded in establishing *Bolam* negligence in the conventional way. This was not one of those "rare cases" where a Claimant was driven to show that

established medical practice was unreasonable. The judge had a considerable body of evidence, firmly expressed by those with proper expertise, to support both the presence of an aneurysm in 1999, and the proposition that any responsible properly qualified neuroradiologist should and would have referred the Respondent for further investigation on the basis of the 1999 MRI scan.

56. This case turns on the facts. The judge rejected Dr Molyneux's evidence on both key issues. He was fully entitled to do so. I would dismiss the appeal.

Lord Justice Henderson:

57. I agree.

Lady Justice Black:

58. I also agree.